
Is Pay for Performance Possible in a Fee-for-Service World?

The following excerpted transcript of a meeting of The Urban Institute, held January 23, 2007,¹ discusses Medicare's future in the era of private fee-for-service plans.

Panel members include:

Bob Berenson, Senior Fellow in the Urban Institute's Health Policy Center; board-certified internist; held senior positions with the Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services (CMS); coauthor of *Medicare, Prospective Payment and the Shaping of U.S. Health Care*.

John Gorman, President and CEO of Gorman Health Group, a leading consulting firm in Medicare managed care; major force behind the creation and design of the Medicare Advantage preferred provider organization (PPO) product; former assistant to the director of HCFA's office of managed care; chief lobbyist on healthcare financing for the National Association of Community Health Centers; Press Secretary and Staff Director for Representative John Conyers, Jr.

Bob Reischauer, President of the Urban Institute and Vice Chair of the Medicare Payment Advisory Commission (MedPAC); former director of the Congressional Budget Office.

Pete Stark, Representative of 13th Congressional District in California; Chair, House Ways and Means Health Subcommittee.

Reischauer: Medicare beneficiaries are offered a choice of the type of delivery system through which they access their Medicare benefits. About 83% choose the traditional fee-for-service system, which is unmanaged, à la carte purchase of services from individual providers, each one of which is paid a set amount for delivering each individual service. The alternative is the Medicare Advantage (MA) component of Medicare un-

der which beneficiaries access their Medicare-promised benefits through a private plan. About 17% of beneficiaries are now in that system. The MA component is growing quite rapidly as a result of incentives provided by the Medicare Modernization Act (MMA). MA comes in many quite different flavors. Some are coordinated-care plans such as health maintenance organizations (HMOs) and other types. There is private fee-

for-service, which is simply Medicare fee-for-service run by a private company. In 2007 an option for catastrophic coverage combined with a medical savings account (MSA) plan is available. There are also special-needs plans, which are a subgroup of the coordinated-care plans. They are closed-enrollment plans that focus on dual-eligibles, people who are in some kind of institution or those with chronic diseases.

All of these MA plans are paid similarly by receiving a monthly capitated payment that is risk adjusted and varies from county to county based on two things: one is the benchmark, and the other is the bid that the plan submitted to CMS. The bid states that the plan will take care of average Medicare folks for this amount of money. Almost always that bid is below what is called the benchmark, and when this happens, CMS says, we'll take 25% of the difference and give it back to the Treasury, and the plan can keep 75%. The plan is supposed to use that 75% to provide extra benefits, lower costs, or refunds so people pay lower premiums for Part B or Part D coverage.

The benchmark varies by counties across the United States. Some counties have a floor—that is, a minimum level that Congress set

in legislation to encourage plans to be offered in areas where MA-type offerings didn't previously exist. The payments provided to MA plans, no matter what their type, exceed by a considerable amount the costs that would be incurred by fee-for-service Medicare for covering these same people. If these people were placed into the fee-for-service system, the government would save considerable money. Estimates have placed this aggregate amount in excess of \$5.2 billion or about \$990 per participant in the programs. The amount of the payment on average exceeds fee-for-service costs by about 12%.

So the question before policy makers is: Why should we pay to have Medicare services delivered through private plans versus traditional fee-for-service Medicare if traditional fee-for-service Medicare by and large is a whole lot cheaper? I think we can identify three possible justifications for paying more. The first is quality. It is conceivable that the quality offered by private plans is superior to that offered by the fee-for-service system, and there are good theoretical arguments for believing this. Medical care really is a team sport. It should be coordinated.

The second justification has to do with accountability, which is likely to be more manageable in the MA component of Medicare than in the fee-for-service world. Up to this point, for the most part, health insurers, Medicare included, have paid whether the right thing is done or the wrong thing is done, whether what is done is of high value or of very marginal value, whether it is done well or it is

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done poorly. The current pay-for-performance emphasis both in the private sector and in the public sector argues that we should pay more for doing the right thing and doing it well. But it is devilishly hard to design and implement an equitable pay-for-performance system in a disaggregated, uncoordinated fee-for-service world.

The third rationale for paying plans more is the belief that in the long run, they will be more efficient, especially if they are coordinated-care plans. Plans can limit excess utilization in ways that fee-for-service cannot.

Looking at these 3 arguments, it is clear that they apply more to HMOs and skilled nursing facilities (SNFs), and possibly to PPOs if they are selecting networks because of the quality of the provider and not because of the price that they can get from the provider for their payment mechanism. The arguments don't apply to private fee-for-service at all or to catastrophic MSA type plans. If we temporarily continue such an excess payment policy, it should be limited to those areas in which we have evidence that these 3 arguments hold. Until that point, I

would endorse MedPAC's plan to level the playing field and pay on a basis of equality.

Berenson: A traditional fee-for-service model isn't the best way to address the needs of patients with 10 chronic conditions who are taking 10 or 15 medications. Theoretically, a private plan that is more attuned to that population could do a better job. The problem is, the performance of private plans hasn't suggested that they do a better job. Traditional Medicare uses administered price controls, but private plans do too; they just pay a lot more. Private plans use capitation and work with providers; therefore, they actually do the same thing that traditional Medicare does—they pay in silos. Medicare so far hasn't received benefits from using private-plan contracting.

The initial deal in the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA) was for Medicare to save 5% by contracting with private plans. In fact, Medicare was losing money. When payments were cut back in the Balanced Budget Act (BBA), plans began to pull out and cut benefits. The most recent MedPAC analysis says that on an aggregate basis, health plans are getting paid 12% more than it would cost to take care of a beneficiary who stayed in the traditional Medicare program.

There are structural advantages that MA plans have over traditional programs, suggesting an unlevel playing field. If you are a Medicare beneficiary and you want catastrophic coverage, a drug benefit, regular Part A and Part B services, and to stay in traditional Medi-

care, you need 3 plans. The MMA specifically prevents Medigap plans from offering prescription drugs to new enrollees, so beneficiaries have to deal with the complexities of 3 plans. If you have a private plan, you can get all you need from 1 plan.

Finally there is this private fee-for-service option that the BBA created. Private fee-for-service, which doesn't have a network by definition, *can* have a selected network. It behaves pretty much like traditional Medicare does by mandating prices on private payers. Essentially, we are paying private fee-for-service plans 19% more than it would cost to cover the same beneficiaries in traditional Medicare. What the traditional program doesn't do well is manage chronic care, and if we focused on programs like Kaiser Permanente's or some of the PACE-like (Program for All-inclusive Care for the Elderly) programs, we might have a good rationale for private plans.

Gorman: The traditional Medicare program is unsustainable. The trustees say the program will be insolvent by 2018. What is killing Medicare at this point is the cost of chronic conditions among beneficiaries. The golden rule of Medicare is that those with chronic conditions comprise the only population in the entire US healthcare system that we know will get sick. Almost 25% of Medicare expenditures are for diabetes. To continue covering these folks, especially with the boomers approaching, in a completely unmanaged fee-for-service environment is fiscal suicide. Short of structural reforms to the program or rationing end-of-life care,

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improving outcomes or managing the demand for the services that Medicare pays for is the only hope.

CMS actuaries estimate that managed care plans are providing seniors almost \$7 billion in additional benefits over traditional Medicare. The plans returned savings of over \$2 billion in 2006 because of the 25% drawback in the MMA. The Part D offerings run by the private sector have far surpassed anybody's initial expectations. The market delivered lower premiums, richer benefits, and higher savings to the government than was ever imagined. Two thirds of plans will offer the drug benefit with zero deductible, even though Congress envisioned a \$250 deductible as the standard. One third of the plans will have what we refer to as "jelly in the donut hole" this year, which was never really imagined.

From a financing standpoint, the biggest development in Medicare policy right now is risk adjustment. This is the government paying more for the sick and less for the healthy, as Medicare should. MA reimbursement just went to 100% risk adjustment several weeks ago after a 5-year run-up. MA has to be given a chance to work. There is nothing

more promising right now in terms of rationalizing reimbursement, countering adverse selection, and aligning incentives to focus on the sickest, most vulnerable beneficiaries. The plans will follow the dollars, and if we align incentives with what the plans are capable of doing, then they have the potential to bring great value in quality and access.

If the government is going to make an investment of this magnitude in these plans, it has every right to lay out very clear expectations for the quality of care and outcomes these plans will deliver.

Independent research has consistently shown that these plans provide better access to care and better quality than traditional Medicare. They offer added benefits of vision, hearing, and dental. There are widespread examples of successful care-management programs.

Private fee-for-service was little more than a naked attempt to outsource claims-paying functions of traditional Medicare. It has not met its promises of accountability for quality or coordinated care. MSAs have the potential to give enrollees skin in the game to make more effective healthcare purchasing decisions. The market must be allowed to work.

Representative Stark: We have overpaid private plans. We have a Part D program that has no regulation by the state or federal governments or anybody else. The government has not paid attention to the operation of fee-for-service as the sustained-growth rate (SGR) payment of physicians demonstrates.

(continued on page 46)

PROVIDER ACTION

Impact to You

Legislative changes will impact whether Medicare managed care continues to grow or decreases in size, which will impact how practices function.

What You Need to Know

Proponents of Medicare managed care cite benefits that include improvements in quality, better accountability, greater efficiency, and provision of additional benefits. On the other side are those who argue that managed care plans are overpaid when compared to fee-for-service Medicare plans.

What You Need to Do

Provide input in the debate so that the clinical benefits of a more efficient and effective system can be realized. If unable to play an active role in the debate, then at least monitor the situation closely so you can make adjustments in your practice in response to likely environmental changes.

Pay-for-performance has become a recent buzz word. I don't think we can measure performance. First of all, I don't think we should pay extra for what we

should expect, which is first-class medical care from hospitals and physicians. I am concerned that we pay extra to profit plans to deliver substandard care.

I predict that the Congress will preserve Medicare as best it can for a long time to come. But we need to decide how we can assess modern technology and relate it to outcomes. We have the highest paid physicians and the highest salaried hospital executives in the world and we spend more than anybody in the world without necessarily having better health statistics. MPM

References

1. Private Plans in Medicare: A 2007 Update—Executive Summary (#7622). The Henry J. Kaiser Family Foundation; July 2007.

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